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May 27, 2010

David Morales
Commissioner
Division of Health Care Finance and Policy
2 Boylston Street
5th Floor
Boston, MA 02116

Re: Proposed Regulations 114.5 CMR 21.00: Health Care Claims Data Submission and 114.5 CMR 22.00: Health Care Claims Data Release

Dear Commissioner Morales,

I am writing on behalf of America's Health Insurance Plans (AHIP) to comment on proposed *Regulations 114.5 CMR 21.00: Health Care Claims Data Submission and 114.5 CMR 22.00: Health Care Claims Data Release.* AHIP is the national association representing nearly 1,300 health insurance plans that provide health insurance coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

AHIP members recognize the efforts of the Massachusetts Division of Health Care Finance and Policy (DHCFP) to establish the guidelines for the creation of this statewide all-payer claims database (APCD) in accordance with *Mass. Gen. Laws Ann. 118G §6* (Health Care Finance and Policy). We appreciate the opportunity to comment on the proposed APCD regulations.

AHIP supports improving care through uniform standards for quality reporting. Improving care through the adoption of uniform standards for quality, reporting, and information technology will provide essential information needed at the point of care to improve shared health care decision-making by the consumer and provider.

While AHIP members recognize DHCFP's efforts to promote greater transparency through these regulations, we are concerned that the current proposal seeks to establish a state-specific database and reporting process in a timeframe that may not be operationally feasible to our members. In addition, our members are concerned about the scale and scope of information required for submission, the protection of confidential consumer and payer information, the proposed fines, the potential application of these requirements to Medicare supplement coverage, which has the potential to skew the data, as well as the broader resource considerations that need to be addressed. We therefore urge DHCFP to amend the proposal and timeframe to adopt

claims reporting standards in accordance with similar database projects throughout the country.[1] What follows are details of our concerns.

1. Uniform Claims Reporting Procedures

AHIP believes that the development of claims reporting systems can significantly contribute to improving the quality of health care across the nation. A critical design element for these databases is harmonization with a set of uniform reporting and methodology standards that ensures interoperability among similar databases. Stakeholders have been working toward a standardized set of data elements and reporting rules that support this goal. Uniform claim reporting and database requirements allows for the collection of the most reliable, demonstrative data available in a state, within a region, and across the country.

As an increasing number of states begin to pursue transparency related measures requiring the collection of claims data, the importance of uniformity cannot be overstated. States such as Minnesota, New Hampshire, Maine, Massachusetts, Tennessee and Vermont have all established state-level APCDs, each with varying levels of reporting requirements; however the Massachusetts proposal in *Regulations 114.5 CMR 21.00: Health Care Claims Data Submission and 114.5 CMR 22.00: Health Care Claims Data Release* extends well beyond what is generally required to support state-level APCD activities. As a result, it will take significant additional time and resources to assess the state specific technical requirements.

A uniform data collection approach also serves to minimize the administrative costs associated with the creation of state APCDs. The procedures and programming required to comply with state-specific claims reporting requirements can be very costly and technical -- requiring significant work and unnecessarily increasing the administrative costs associated with providing health insurance coverage. We note that the adoption of uniform standards consistent with other state data collection projects is supported by the APCD's enabling statute. For this reason, we urge DHCFP to renew its efforts to achieve uniformity with existing standards for the reporting of claims data and the creation of an APCD.

2. Adequate Protections for Individually Identifiable Data

Our review of the data elements required for submission to the state database under *Appendix A of 114.5 CMR 21.00* identified concerns with respect to the protection of consumer protected

[1] The National Claims Data Management System provides technical and administrative support for the Maine Health Data Processing Center, Minnesota's Health Reform Initiative Encounter Data Collection, the New Hampshire Comprehensive Health Information System, the Vermont Healthcare Claims Uniform Reporting System, and the Massachusetts Health Care Quality and Cost Council.

health information[2] (PHI) and other individually identifiable data. Of utmost importance to AHIP members is protection of a consumer's confidential information and we note that the proposed rules do not incorporate guidelines to ensure the continued protection of this information. We suggest that the proposed rules be amended to explicitly incorporate the privacy protections and standards that will be afforded the PHI and other data that is collected from HIPAA-covered entities and non-HIPAA entities and then stored by the APCD. We also encourage the adoption of reporting processes that at least meet and are consistent with the federal HIPAA privacy and security requirements for uses and disclosures of PHI.[3]

In addition, we are concerned that the proposed list of data elements requires the submission of data that goes beyond the minimum amount necessary for the state to create and maintain an APCD. *Mass. Gen. Laws Ann. 118G §6* requires that "the Division shall, before adopting regulations under this section, consult with other agencies of the commonwealth and the federal government, affected providers, and affected payers, as applicable, to ensure that the reporting requirements imposed under the regulations are not duplicative or excessive." Furthermore, the same statute also requires that "data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability." We therefore request that a thorough review of the data elements be conducted to safeguard the personal privacy of personal health information data and require reporting of only those elements that are needed to achieve the purposes as outlined in the statute.

3. Timeline for Implementation of Reporting Requirements & Imposition of Fines

To maximize the benefits of the APCD and to ensure a smooth implementation of the new reporting requirements, we recommend that DHCFP provide a longer time period from the date of adoption to the date when data is to be submitted. An adequate period of time will allow for claims submission procedures to be tested and ensure that the system functions properly without significant errors. We note that both proposed regulations do not acknowledge the need for testing of the system and we are concerned that a lack of adequate implementation time could pose a threat to consumers, carriers, and the integrity of the claims database itself. We urge DHCFP to delay the first submission date until any technical issues are resolved and plans can make changes to their systems to conform to the new reporting requirements. We request that plans be given at least six months between the resolution of outstanding issues and the first data submission date. This approach protects entities from liability for errors that may occur during the testing phase while providing sufficient time to implement these highly technical and complex reporting requirements. Also, the proposed rules, as currently drafted, are set to

[2] This is a term used in the federal Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, located at 45 C.F.R. §160.103

[3] *Please see* 45 C.F.R. Part 160, 162, and 164 for more information.

become effective on July 1, 2010 and we note that this provides a very short implementation window (about 30 days).

We also believe the penalties section in *114.5 CMR 21.04* is unclear. It states that if any payer fails to submit required data to DHCFP on a timely basis, or fails to correct submissions rejected because of errors, DHCFP or its designee shall provide written notice to the payer. If the payer fails to provide the required information within two weeks following receipt of said written notice, DHCFP will take all necessary steps to enforce this provision to the fullest extent of the law. We believe further clarification is needed to explain what those penalties might actually be.

4. Ensuring the Data Collected Will Be Useful and Not Hinder Competition and Raise Prices for Consumers

The proposed rules would require the submission and release of private health plan information which we believe is confidential and proprietary in nature. For example, the rule requires all private health care payers to submit information on "provider payment methods and levels." Information about the rates at which a particular provider and a particular insurer have contracted is generally not useful to consumers. While consumers may be responsible for copayments and deductibles, they are generally not responsible for "rates charged" by providers. Moreover, the release of provider payment methods and levels has the potential to harm consumers. The Federal Trade Commission has found that the disclosure of individually negotiated prices may create harm to consumers, by setting a "price floor" for providers, which will lead to higher prices for consumers.[4] To the extent that provider payment information is disclosed, it should comply with antitrust guidelines and be disclosed in aggregated form to prevent the unintended consequence of inhibiting competition and raising prices for consumers.

Additionally, some of the other business data requested (e.g. medical and administrative expenses by market sector, premium information, and actuarial assumptions used in rate development) are unrelated to the types of data that are typically included in an all payer claims database. In fact, other states that have passed similar laws do not currently request such information, suggesting that this type of data may go beyond the scope of what is useful. More important, the release of such information could inadvertently allow companies to access competitors' projected or realized cost structures, and ascertain competitors' future business plans. We believe there is an important public interest to be served in taking steps to ensure that proprietary business data is either not collected or if collected, not released so as to undermine or compromise competition which ultimately will harm consumers and may raise health costs.

5. Requirements of Data Submission

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[4] See FTC, *Letter to New Jersey General Assemblywoman Nellie Pou* (April 17, 2007) at 11 – 12 and FTC, *Letter to Virginia House of Delegates Member Terry G. Kilgore* (October 2, 2006) at 13.

The data elements outlined in the proposed rule include a number of data points that are not collected by health carriers or are not submitted by health care providers as part of the current claims submission and payment processes. Requiring payers to capture and store additional data beyond what is needed to support business operations is costly and would require many carriers to modify numerous core systems and warehouses. This requirement adds costs and complexities resulting in additional administrative costs that will ultimately impact the member. As a result, we suggest that implementation of these new reporting requirements will be enhanced, and the transition eased, if the following data fields are designated as optional fields for reporting: 1) designated primary care physician (PCP), 2) PCP ID, 3) drug information, 4) diagnosis related group (DRG), and 5) rendering provider specialty. We understand that the technical manual advises data suppliers to explain any missing data elements (such as those noted above); however, greater clarity around the treatment of optional data elements would be helpful.

We note that *114 CMR 22.03(1)(d)* is an open-ended requirement and appears to give DHCFP unlimited authority to request data from payers. Payers need extra time to prepare and tabulate additional information and reporting requirements. We suggest that additional data requests from DHCFP should go through a public comment process that will give payers adequate time to engage DHCFP in a dialogue regarding the value of the data and to revise submitted reports.

Finally, while AHIP supports the creation of a Data Release Committee, we note that in *114 CMR 22.03*, the Commissioner is granted sole discretion to approve applications for data, though members of the public have an opportunity to provide written comment and the Commissioner may utilize the data release committee as he/she deems appropriate. Entities that provide data and who are most knowledgeable about the contents provide a valuable role in considering key points regarding use and release of the data. We suggest including the opportunity for notice and comment by the entities whose data will be released.

Furthermore, greater assurances are needed in order to accurately consider requests for data and we believe an assessment of the following is imperative and should be considered by the Data Release Committee:

- the background, purposes, and health issues to be addressed;
- safeguards to maintain the confidentiality of data;
- the minimum needed specified data items required including how the project can improve care to patients; and
- a statement of how the project can improve care.

In addition, we refer you to the Data Release Committee established in New Hampshire[5] which includes procedures for data use agreements, mechanisms to protect the identity of patients, employer groups or purchaser groups contained in the data, publication guidelines, destruction of data procedures, and penalties for inappropriate release or use of the data.

6. Clarification of Scope of Reporting Requirements

We encourage DHCFP to limit the application of the claims reporting requirements to comprehensive, major medical insurance. We note that the inclusion of Medicare supplement plans has the strong potential to skew the claims data because the vast majority of claim reimbursements under these policies are secondary to Medicare benefits. These policies generally cover a large portion of expenses not covered by Medicare, such as Medicare's coinsurance, copayments, deductibles and other out-of-pocket costs. There are only a limited number of instances (e.g., services not covered by Medicare and foreign travel situations) where the Medicare supplement coverage is primary. For your reference, we attach a copy of recent guidance issued by the Vermont Department of Banking, Insurance, Securities and Health Care Administration advising insurers that they would no longer be required to submit claims file for Medicare supplement policies covering Vermont residents. We encourage DHCFP to similarly limit the application of Massachusetts' claims reporting requirements to ensure the collection of pertinent and meaningful information in the most efficient manner.

In addition, we submit that the other supplemental health insurance products should be similarly excluded from these requirements. These products, commonly referred to as "excepted benefits" under federal law[6], are not intended to replace comprehensive health coverage, but rather offer consumers additional insurance protection for non-medical expenses not covered by their primary health insurance policy. We believe that these federal product exemptions are consistent with the exemptions from the definition of "health benefit plan' under Chapter 176J, Section 1 of Massachusetts law.

Finally, DHCFP should clarify the scope of reporting requirements to preemptively resolve extraterritorial issues. We strongly encourage DHCFP to clarify that the claims data submission requirements (e.g., Section 21.03(4)) only apply to claims data pertaining to enrollees who: (1) are Massachusetts residents; (2) receive health care services in Massachusetts; and (3) are covered by carriers licensed in Massachusetts. Similarly, to the extent that payers are required to submit other data not directly related to claims (e.g., reserves and surpluses), such data submission requirements should only apply to plans which are licensed in, and cover enrollees

[5] See N.H. Code Admin. R. He-W 950.06 Release of Limited Use Health Care Claims Research Data Sets.

[6] See 42 U.S.C. 300gg-91(c) for the federal definition of "excepted benefits" which includes, but is not limited to: hospital indemnity or other fixed indemnity insurance, accident-only coverage, specified disease or illness policies and disability income insurance.

who are residents of, Massachusetts. To do otherwise would raise state jurisdictional issues which resolution could significantly delay the implementation process.

7. Data and Privacy Protections

Health insurance plans have been at the forefront of protecting the privacy and security of consumers' health information. We believe the Health Insurance Portability and Accountability Act (HIPAA) sets a consistent framework for covered entities to ensure that individuals' health information remains private and secure.

In addition to the HIPAA privacy and security requirements, health insurance plans are required to comply with the privacy requirements in the Health Information Technology for Economic and Clinical Health (HITECH) Act, as included in the American Recovery and Reinvestment Act (Pub. L. No. 11-5) which set federal data breach requirements.

We support state requirements that are consistent with the HIPAA and HITECH requirements. As such, we believe the regulation *114.5 CMR 21.00 and 114.5 CMR 22.00* should include specific data and privacy protections. We suggest the addition of language where:

- the Commissioner is responsible for ensuring data integrity and security; and
- patient privacy is protected as required by state and federal laws.

Additionally, we request that the Commissioner consider entering into appropriate contractual agreements with data submitters so all parties are aware of each party's responsibilities and financial liability should a security breach occur.

As previously noted, these regulations purport to collect plan competitive information that is not necessary for an APCD and we are opposed to its inclusion of the requested data submission. If however, DHCFP intends to collect such information, we believe additional data and privacy protections are required for data (consistent with that required by *Mass. Gen. Laws Ann. Chapter 66A – Fair Information Practices*) including:

- as it relates to its corporate plan or reorganization;
- that contains either a trade secret or contract information that would, if revealed, substantially and adversely affect the ability of the data submitter, its affiliated interests or the other persons or entities with which the data submitter is engaging in a joint venture or commercial action to compete with other entities offering or proposing to offer the same goods and services in the same market;
- that would, if revealed, substantially and adversely affect the ability of the data submitter or its affiliated interest to obtain financing on reasonable terms in competition with others seeking similar types of capital;

- that could lawfully be concealed under applicable laws governing financial transactions; or
- that is restricted under a confidentiality agreement between the data submitter and its business partner

8. Definition of "Data Release Committee"

Regulation *114.5 CMR 22.00* establishes a "Data Release Committee" to review applications for APCD data and ensure that external releases of confidential information conform to DHCFP policies. As previously stated, AHIP supports the creation of a Data Release Committee, however, we believe it is imperative that this Committee include at least one health plan representative given that a health plan representative will possess a needed level of expertise regarding the data submitted to DHCFP. A health plan representative will be in the best position to explain why certain confidential information should or should not be released or whether the intended use of the data is appropriate. We request that DHCFP amend the composition of the Committee to include at least one health plan representative.

In summary, we encourage DHCFP to adopt a set of standards that is consistent with other state all-payer database and claim reporting requirements to ensure uniformity and interoperability with these systems. In addition, we request that the proposal be amended to limit the disclosure and transfer of personally identifiable information, in accordance with federal privacy and security standards, and to delay the effective date to ensure ample time for implementation.

Thank you for the continued opportunity to provide our views on these very important issues. We look forward to further discussions with you and your staff.

Sincerely,

Brian M. Quigley

Brian Quigley
Regional Director

Enclosure

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ATTENTION: Medicare Supplement Insurers:

Notification Regarding VHCURES Regulation H-2008-01 Exempting Medicare Supplement Insurers from Requirement To Submit Claims Data

April 15, 2010

The purpose of this notice is to clarify Vermont reporting requirements for the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) pertaining to Medicare Supplement insurers subject to Department Regulation H-2008-01. This notification is an update to and replaces the prior notification addressing Medicare Supplement reporting dated March 26, 2009 titled, "Clarification of VHCURES Reporting Requirements: Medicare Supplement."

Data obtained through Regulation H-2008-01 is critical to a complete understanding of Vermont's health care system, yet the Department remains amenable to suggestions for revising reporting requirements in a manner that reduces the burden on insurers where such an accommodation will not limit our access to pertinent data. The Department also remains committed to ongoing efforts to harmonize reporting requirements with similar data collection initiatives underway in other states in order to promote data uniformity and reporting efficiencies for insurers doing business in multiple states. We offer the following guidance in the spirit of continuing to collect pertinent information that is meaningful to the State in an efficient manner. If you have any questions regarding the following guidance, contact Dian Kahn (Dian.Kahn@state.vt.us) at the Department.

Revised Scope Limits Medicare Supplement Data Collection to Eligibility Records

Effective immediately, the State of Vermont will no longer require the submission of claims files by insurers providing Medicare Supplement policies covering Vermont residents. ***However, insurers meeting a minimum threshold of 200 covered Vermont lives are required to submit the eligibility files for Vermont residents per the reporting requirements specified under H-2008-01.*** If insurers choose to continue to include the claims data in the file submissions, the Department will accept these files.

Questions About Specific Reporting and Coding Requirements Pertaining to Eligibility Files

For technical assistance with questions about coding and file submission, please contact Onpoint Health Data at vtinfo@onpointcdm.org

Q: How should ME003 be coded?
A: ME003 should be coded as "SP".

Q: For ME007, what code should be used for individual plans when there is an insured and a spouse or an insured and dependent child?
A: Insured and spouse should be coded as "ESP" and insured and dependent child should be coded as "ECH".

Q: For ME008, ME011, ME101 – 106, please explain the difference between a "Subscriber" and a "Member" in individual coverage.
A: As defined in the Regulation H-2008-01, "Subscriber" is the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan. "Member" is the insured subscriber and any spouse and/or dependent covered by the subscriber's policy.

Q: For ME008 and ME011, we do not have Social Security numbers for all insureds. Every customer does have a Client Number. Can that identifier be used? If so, does this field need to be encrypted?
A: ME008 must be populated with the subscribers SSN # if available. If not, ME009 must be populated with the unique identifier that describes the subscriber. ME011 must be populated if the members SSN is available. If SSN is not available in fields ME008 or ME011, please leave the field as null.

Q: For ME017, we have only the first five zip code digits for some insureds. In these situations, will a five-digit code be acceptable in lieu of variable length fields?
A: Yes, five digit zip codes will be accepted.

Q: Related to ME101, Section 5 A. (12) of H-2008-01 states we are not to identify individual policy owners with non-group coverage. Our exposure is with Individual Medicare Supplement plans.
A: Section 5: A. (12) of H-2008-01 applies to the reporting of the Insured Group Name associated with each Insured Group or Policy Number that is reported in ME006. Individual Medicare Supplement policies will not have an Insured Group Name or Policy Number associated with them. Therefore, ME032 should be populated as IND for individual Medicare Supplement policies.

The proposed action is for insured group name to be populated as follows:
* Actual insured group name for all group policies
* The word IND for individual or non-group policies
* The work BLANK if group name information is not available

Q: Are elements ME101 through ME106 to be left blank?
A: ME101 through ME106 are required data elements. These elements will be encrypted before leaving your office using the Onpoint Claims Data Manager software.